INDEPENDENT LABORATORY AND OTHER LAB AND X-RAY SERVICES MANUAL

Kentucky Medicaid Program.' Independent Laboratory and Other Lab and X-Ray Services Benefits Policies and Procedures

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAID PROGRAM

INDEPENDENT LABORATORY AND OTHER LAB AND X-RAY SERVICES MANUAL

POLICIES AND PROCEDURES

Cabinet for Health Services
Department for Medicaid Services
Division of Program Services

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SECTION I - INTRODUCTION

I. INTRODUCTION

A. Independent Laboratory and Other Lab and X-ray Services

The Kentucky Medicaid Independent Laboratory and Other Lab and X-ray Services Manual was formulated to provide Medicaid providers with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual shall provide basic information concerning coverage and policy. It shall assist providers in understanding what procedures are reimbursable, and shall also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which shall allow policy and procedural changes to be transmitted to providers in a form which may be immediately incorporated into the manual (i.e., page 4.6 might be replaced by new pages 4.6 and 4.7).

Precise adherence to policy shall be imperative. In order that claims may be processed quickly and efficiently, it shall be extremely important that the policies and instructions described in this manual be followed. Any questions concerning agency policy shall be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health Services, 275 East Main Street, Frankfort, Kentucky 40621, or phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services shall be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Health Services, 275 East Main Street, Frankfort, Kentucky 40621, or phone (502) 564-2687. Questions concerning billing procedures or the specific status of claims shall be directed to the fiscal agent (see Appendix: Kentucky Medicaid Fiscal Agent).

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients. Information regarding the fiscal agent shall be included in Appendix I.

KENTUCKY MEDICAID PROGRAM

SECTION II

II. KENTUCKY MEDICAID PROGRAM

A. General

The Kentucky Medicaid Program shall be administered by the Cabinet for Health Services, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the Health Care Financing Administration.

Title XIX is a joint federal and state assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of medical care. The basic objective of the Kentucky Medicaid Program shall be to aid the medically indigent of Kentucky in obtaining quality medical care.

The Department for Medicaid Services shall be bound by both federal and state statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services. Therefore, Kentucky Medicaid shall request a return of any monies improperly paid to providers for noncovered services.

The Kentucky Medicaid Program shall not be confused with Medicare. Medicare is a federal program, identified as Title XVIII, basically serving persons sixty-five (65) years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. Kentucicky Medicaid coverage and limitations of covered health care services specific to the Independent Laboratory and Other Lab and X-ray Services Program shall be specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services, Cabinet for Health Services, shall bear the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of Kentucky Medicaid. The fiscal agent for the Department for Medicaid Services shall make the actual payments to the providers of medical services who submit claims for services within the scope of covered benefits provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits shall be a responsibility of the local Department for Social Insurance offices, located in each county of. the state.

C. Advisory Council

The Kentucky Medicaid Program shall be guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with conditions set forth in KRS 205.540, the Council shall be composed of eighteen (18) members, including the Secretary of the Cabinet for Health Services, who serves as an exofficio member. The remaining seventeen (17) members shall be appointed by the Governor to four (4) year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and shall be appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members shall be citizens of Kentucky who share a basic concern for health care in this state.

In accordance with the statutes, the Advisory Council shall meet at least every three (3) months or as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes shall make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees shall be determined by the professional organization that the technical advisory committee represents. The technical advisory committees shall provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council shall appoint subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible recipients.

The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical costs of program recipients. If the recipient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the recipient's medical expenses. The Medicaid Program shall be payor of last resort. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided. If the health care provider receives payment from the Medicaid Program before knowing of the third party's liability or receiving a third party payment, the health care provider shall refund that payment amount issued by Medicaid. The amount then payable by Medicaid shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, these policies are as follows:

SECTION II - KENTUCKY MEDICAID PROGRAM

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient shall select the provider from whom he wishes to receive his medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid provided they notify the recipient of their liability in advance of the treatment.

Providers of medical services or authorized representatives shall attest by their signatures that the presented claims shall be valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment, or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

All claims and substantiating records shall be auditable by both the Government of the United States and the Commonwealth of Kentucky.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. If computer audits or edits fail to function properly the application of policies in this manual shall remain in effect. Therefore, claims shall become subject to postpayment review by the Department.

All claims and payments shall be subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services for Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

Provided services shall be periodically reviewed for recipient and provider abuse. Willful abuse by the provider may result in suspension from Medicaid participation. Abuse by the recipient may result in placement of the recipient into a managed care program or a restricted program such as the Lock-In Program.

Claims shall not be oaid for services outside the scope of allowable benefits within a particular program specialty.. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Physicians shall notify recipients in advance of his liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

E. **Public Law 92-603 (As Amended)**

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Sate plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment or payment is authorized, or

(4) having made application to *receive* any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(l) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months of the adjudication date of Medicare or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows: "The date of receipt is the date the agency received the claim as indicated by its date stamp on the claim." For Kentucky, the date received is included within the Transaction Control Number (TCN) which is assigned to each claim as it is received by the fiscal agent. The second through the sixth digits of the TCN identifies the year and day of receipt, in that order (e.g., 09528743450010 = October 13, 1995). The day is represented by a Julian date which counts the days of the year sequentially (January 1 = 001 through December 31 = 365 or 366). In order for Kentucky Medicaid to consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid or the Medicaid fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation to timely billing. ONLY twelve (12) months shall elapse between EACH RECEIPT of the aged claim by Kentucky Medicaid or the fiscal agent.

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary physician or family doctor. The primary physicians shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services.'

Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories shall be covered by KenPAC. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

Recipients select a primary care physician who has agreed to participate in both Medicaid and KenPAC programs. Recipients may change primary care physicians, if they wish. Likewise, a physician may choose to disenroll a particular recipient. Recipients not selecting a primary physician shall be assigned one by the Department.

Primary physicians shall arrange for physician coverage twenty-four (24) hours per day, seven (7) days per week. The recipient shall be able to contact the primary physician or another medical practitioner designated by the primary physician to receive necessary medical care at all hours of the day and night.

A twenty-four (24) hour access telephone number shall be provided by the primary physician. This telephone number shall be printed on the recipient's MAID card.

Referrals may be made by the primary physician to another physician for specialty care or for primary care during his absence or non-availability. Special authorization or referral form shall not be required. Referrals shall occur in accordance with accepted practices in the medical community. For billing purposes, the primary physician shall provide the specialist or other physician with his provider authorization number, which shall be entered on the billing form to signify the service has been authorized. Certain designated services shall not require prior approval by the KenPAC provider.

Preauthorization from the primary physician shall not be required for services provided for emergency services. If post treatment authorization cannot be obtained from the primary care physician, the provider may contact the Medicaid Program to obtain an authorization number before submitting a claim.

An "emergency medical condition" shall be defined as:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part; or

B. with respect to a pregnant woman who is having contractions:

(1) that there is inadequate time to effect a safe transfer to another hospital before delivery; or
(2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

A "transfer" shall be defined as the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include a movement of an individual who:

A. has been declared dead; or

B. leaves the facility without the permission from the facility.

H. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

In accordance with 907 KAR 1:677, Medicaid Recipient Lock-In, the Department shall determine the validity of the alleged over-utilization and take appropriate action, including the placement of a recipient into a restricted program, known as Lock-In. Under the Lock-In program, the Department shall assign one (1) physician to serve as a manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card. Claims resulting from a referral shall be considered for payment, provided that the name of the lock-in provider appears in the appropriate referral fields of the claim form.

Any questions concerning the Lock-In Program may be directed to the Surveillance and Utilization Review Branch at 502-564-2393.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PROVIDER PARTICIPATION

A. General Information

In 1968 the United States **Congress amended the portion of the Social Security laws concerning medical assistance programs to require that state programs have agreements with** EVERY PERSON OR INSTITUTION **providing medical services to the program's recipients. The appropriate information as outlined in this section shall be submitted to the Department for Medicaid Services Provider Enrollment Section before participation in the Kentucky Medicaid Program is approved. Changes of address, provider specialty or tax identification number shall be reported immediately** IN WRITING **to Provider Enrollment and signed by the physician or authorized office personnel.**

For purposes of participation in the Kentucky Medicaid Program, an eight (8) digit Medicaid provider number shall be assigned to each provider. Independent Laboratory provider numbers have a prefix of "37" and Other Lab and X-ray provider numbers have a prefix of "86". Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date of termination shall not be payable.

Proof of current Clinical Laboratory Improvement Amendment (CLIA) certification for Independent Labs, and current Radiological licenses for Other Lab and X-ray providers shall be required annually for the provider to remain enrolled.

NOTE: Non-submission of the above proof of certification or proof of current licensure shall result in loss of eligibility of the provider and **denial of claims submitted for payment.**

B. Individual Provider

Any provider who is certified under Clinical Laboratory Improvement Amendment (CLIA) to perform laboratory services and is supervised by a board certified pathologist as a laboratory Physician Director may participate in the Kentucky Medicaid Program by enrolling as an Independent Laboratory in the Kentucky Medicaid Program and request payment for covered medical services provided to eligible recipients.

Any provider licensed to perform radiological services, certified by Medicare and supervised by a Physician Director may participate in the Kentucky Medicaid Program by enrolling as an Other Lab and X-ray Services provider in the Kentucky Medicaid Program and requesting payment for covered medical services provided to eligible program recipients. A copy of this license or certification or any renewal of license or certification shall be submitted by the provider and maintained on file in Kentucky Medicaid Provider Enrollment Section.

Providers who choose to participate in the Kentucky Medicaid Program shall sign and submit a Provider Agreement (MAP-343), a Certification on Lobbying (MAP-343A), and a Provider Information Form (MAP-344) to Provider Enrollment. By signing these agreements and completing this process, providers agree to abide by the rules, regulations, policies and procedures related to the reimbursement system. By signing these agreements, providers shall agree to maintain and make available to representatives of the state and federal governments any medical records and information related to the Medicaid services provided, as required by the Kentucky Medicaid Program.

If a provider enrolls in Kentucky Medicaid and chooses to submit claims electronically, the provider shall complete and submit a Provider Agreement Addendum (MAP-380). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency shall also complete and submit an Agreement (MAP-246). These completed forms shall be mailed directly to the Department for Medicaid Services, Provider Enrollment, 275 East Main Street, Frankfort, Kentucky 40621.

Examples of all enrollment forms referenced shall be contained in the Appendices of this manual for review.

Providers located outside Kentucky may participate in Kentucky Medicaid by completing the enrollment process. Providers located outside the United States and its territories shall not be granted enrollment in the Kentucky Medicaid Program unless special authorization is obtained through the Cabinet for Health Services, Department for Medicaid Services.

C. Freedom of Choice Concept

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the Program for the medical care provided. Similarly, the recipient shall have the freedom to select the primary provider of choice except for those recipients placed in the "lock-in" program. The signing of the application for participation shall not in any way infringe upon the individual freedom of any physician provider.

D. Medical Records

Medical records in the office, clinic, hospital, or other health care facilities shall substantiate the services billed by the provider. The medical records shall reflect the nature and extent of counseling and coordination of care and be supportive of medical necessity. Physician notes shall be contained in these medical records. These notes shall be entered personally by the physician or typewritten if signed by the physician. All records shall be signed and dated.

The results of diagnostic tests, including negative test results, billed by the provider shall be included in the medical record of the recipient. The date of the test shall be the date of service reported on the claim form submitted to Kentucky Medicaid for payment.

Medical records of Kentucky Medicaid Program recipients shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute. These records, and any other information regarding Medicaid Program paid claims shall be maintained in an organized central file, provided to the Department upon request, and made available for inspection and photocopy by Department personnel or its representative.

E. Termination of Provider Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department for Medicaid Services' administrative regulations which address the terms and conditions for provider termination and procedures for provider appeals.

PROGRAM COVERAGE

SECTION IV

SECTION IV - PROGRAM COVERAGE

IV. PROGRAM COVERAGE

A. Physicians Orders

Laboratory services and Other Lab and X-ray Services shall perform tests only at the written or electronic request of a physician, dentist, a person authorized by a physician or dentist, or other person operating under their licensed scope of practice, for the care and treatment indicated in the management of illness, injury, impairment, maternity care, or for the purpose of determining the existence of an illness or condition in a recipient. The request shall be maintained in the files of the laboratory or Other Lab and X-ray provider in a manner which shall allow the Medicaid Program to verify that its policies are being met. Independent laboratories and Other Lab and X-ray Services shall be required to maintain the original request slip from the referring provider, the test results including negative test and the Remittance Advice (RA) payment voucher.

B. Independent Laboratory Services Clinical Laboratory Improvement Amendment (CLIA) Certification

Effective September 1, 1992, CLIA certification shall be required for Medicaid coverage of laboratory procedures which the laboratory is certified by the Health Care Finance Administration (HCFA) to perform.

Changes in laboratory certification status and their effective dates shall be determined by the appropriate state licensing and regulation survey performed biannually. To ensure that the Medicaid Program has the CLIA certification information, each provider shall submit to the Department for Medicaid Services, Provider Enrollment Section, a copy of the provider's CLIA certification. Any future changes in this certification shall be provided by computer updates from the state survey agency on HCFA's computer system.

Each independent laboratory shall be certified by CLIA requirements to perform specific categories of service. If billing the Department for Medicaid Services, each independent laboratory shall bill those tests which fall within their approved categories of service.

SECTION IV - PROGRAM COVERAGE

The federal Health Care Financing Administration shall certify independent laboratories. The procedures that each independent laboratory is certified to perform shall be determined by the survey performed by the state licensing agency. Independent laboratories that meet these requirements shall be in one (1) or more of the categories listed below:

010 Histocompatibility testing

100 Microbiology

- 110 Bacteriology
- 115 Mycobacteriology
- 120 Mycology
- 130 Parasitology
- 140 Virology
- 150 Other Microbiology

200 Diagnostic Immunology

- 210 Syphilis Serology
- 220 General Immunology

300 Chemistry

- 310 Routine Chemistry
- 320 Urinalysis
- 330 Endocrinology
- 340 Toxicology
- 350 Other Chemistry

400 Hematology

500 Immunohematology

- 510 ABO Group & RH Type
- 520 Antibody Detection (transfusion)
- 530 Antibody Detection (nontransfusion)
- 540 Antibody Identification
- 550 Compatibility Testing
- 560 Other Immunohematology

SECTION IV - PROGRAM COVERAGE

600 Pathology

610 Histopathology
620 Oral Pathology
630 Cytology

800 Radiobioassay

900 Clinical Cytogenetics

C. CPT Code Coverage

Independent laboratory procedures covered by the Kentucky Medicaid Program shall be determined by the Department for Medicaid Services.

Coverage shall be based on codes from the Physicians Current Procedural Terminology (CPT) Book which correspond to procedures which each laboratory is certified by CLIA to perform. Non-covered services are listed in Section IV, K.

CLAIMS WITH A DATE OF SERVICE ON OR AFTER JANUARY 1, 1995 USE 1995 CPT PROCEDURE CODES FOR MEDICAID COVERED SERVICES.

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1996 CPT PROCEDURE CODES FOR MEDICAID COVERED SERVICES.

D. Independent Laboratory Services-Complete blood count procedure codes:

If three (3) or more of the following laboratory services are performed on the same day, providers shall bill procedure code 85031 with one (1) charge. This application of policy shall be subject to enforcement by the postpayment review of claims.

85007	85023
85009	85024
85014	85025
85018	85027
85021	85041
85022	85048

E. Independent Laboratory Services-Pregnancy testing procedure codes

Quantitative Chorionic Gonadotropin	84702
Qualitative Chorionic Gonadotropin	84703

F. Independent Laboratory Services-Acquired Immune Deficiency Syndrome (AIDS) testing procedure codes

HTLV-III (Antibody Detection)	86687, 86688, 86689
Western Blot (Confirmatory)	86689

G. Independent Laboratory Services-Oral pathology procedure codes

Surgical pathology, gross & micros. exam	88304
Special stains, histochemical staining	88314
Electron microscopy, diagnostic	88348
Electron microscopy, scanning	88349
Morphometric Analysis, skeletal muscle	88355
Morphometric Analysis, nerve	88356
Morphometric analysis, tumor	88358

SECTION IV - PROGRAM COVERAGE

H. Independent Laboratory Services-Anatomic pathology procedure codes:

Only one (1) of the procedure codes 88300 through 88309 shall qbe billed for specimens (single or multiple) removed from a single anatomic site. Additional units may be used for specimens from more than one (1) anatomic site requiring examination and report. NOTE: Units shall not be used unless multiple sites are involved. This application of policy shall be subject to enforcement by the postpayment review of claims.

I. Independent Laboratory Services-"By-Report" procedure codes:

"By-Report" procedure codes shall require a copy of the physician's or dentist's order to be attached to the HCFA-1500 claim form.

Documentation shall include the referring physician's or dentist's name, date of service and the recipient's name. Medicaid Services reserves the right to request additional information.

"By-Report" services are individually reviewed by medical consultants.

"BY-REPORT" PROCEDURE CODES
(Listed from left to right in numerical order)

80299	80999	81099	84999	85999	86069
86074	86999	87999	88199	88299	88399
89399					

SECTION IV - PROGRAM COVERAGE

J. Independent Laboratory Services-Non-covered services:

1. Medicaid non-covered services shall be those procedures which are also non-covered by Medicare.

2. Below is a list of diagnostic tests that shall not be covered:

Amylase, blood isoenzymes, electrophoretic
Chromium, blood
Guanase, blood
Zinc sulphate turbidity, blood
Skin test, cat scratch fever
Skin test, lymphopathia venereum
Circulation time, one test
Cephalin flocculation
Congo red, blood
Hormones, adrenocorticotropin quantitative animal test
Hormones, adrenocorticotropin quantitative bioassay
Thymol turbidity, blood
Skin test, actinomycosis
Skin test, brucellosis
Skin test, leptospirosis
Skin test, psittacosis
Skin test, trichinosis
Calcium, feces, 24-hour quantitative
Starch, feces, screening
Chymotrypsin, duodenal contents
Gastric analysis, pepsin
Gastric analysis, tubeless
Calcium saturation clotting time
Capillary fragility test (Rumpel-Leede)
Colloidal gold
Bendien's test for cancer and tuberculosis
Bolen's test for cancer
Rehfuss test for gastric acidity
Serum sermucoid assay for cancer and other diseases
Dipstick urinalysis
Culture and fertilization of oocyte(s)

The providers' adherence to the application of policies regarding non-covered services shall be monitored through postpayment review of claims.

3. The following services shall be excluded from Program coverage:

   a. Services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. Necessity shall be monitored through the postpayment review process.

   b. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment. This shall be monitored through the postpayment review process.

   c. Services listed as non-covered.

4. Services provided to residents of a nursing facility, or intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD) and receive coverage from Medicaid, shall not be billed directly by the independent laboratory. Laboratory services provided to residents of these facilities shall be billed to the Program only by the facility, as these services are part of the facility's cost of providing care. Facilities and independent laboratories may enter into contractual agreements to provide necessary services to Medicaid residents. The schedule of procedures payable to independent laboratories shall not apply to these residents. The only exception shall be the billing for patients dually eligible for Medicare and Medicaid. The laboratory shall bill Medicare before Medicaid will reconsider reimbursement.

   Patients in personal care status shall be considered by the Medicaid Program as independent self-care residents. Medicaid shall not reimburse the facility for recipients in personal care status. Independent Laboratories shall bill Medicaid directly for services provided to patients in personal care status.

5. Laboratory handling fees shall be treated as non-covered services.

K. Other Lab and X-ray Services-Program Coverage

The Other Lab and X-ray Services Program shall follow these guidelines in the provision of Kentucky Medicaid covered radiological services.

Covered services include radiological procedure codes in the CPT-4 book ranging from 700 10 through 79999, except:

(1) The following CPT-4 codes shall also be considered covered services for this provider type:

93015	93312	93880	93924	93970	93980
93016	93320	93882	93925	93971	93981
93017	93321	93886	93926	93975	93990
93018	93325	93888	93930	93976	
93307	93350	93922	93931	93978	
93308	93875	93923	93965	93979	

(2) Appropriate reports (e.g., operative report, emergency department report, anesthesia report, consultation report, etc.) shall be required and attached to claims reporting the following procedure codes:

76499	78099	78599
76999	78199	78699
77299	78299	78799
77399	78399	78999
77499	78499	79999
77799		

(3) The following list of procedure codes non-covered for the Other Lab and X-ray Program.

76001	78190	78891
76948	78890	78990

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. The Deficit Reduction Act (DEFRA) of 1984 allows hospital outpatient and nonpatient laboratory services to be paid in accordance with a fee schedule developed by Medicare.

The Kentucky Title XIX (Medicaid) Program shall not reimburse an independent laboratory for any service at a rate which exceeds: (1) The laboratory's actual charge for the service, or (2) The Title XVIII Part B (Medicare) reasonable or prevailing charge for the service.

B. Non-duplication of payment as required by 45 C.F.R. Section 250.30 shall be assured, as follows:

1. If a recipient makes payment for a covered services, and the payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to Medicaid and the bill for the same services shall not be paid by Medicaid.

2. If Medicaid makes payment for a covered service and the provider accepts the payment made by Medicaid, the amounts paid shall be considered payment in full; the bill for the same service shall not be tendered to the recipient, or payment for the same service accepted from the recipient.

3. All items or services considered by Medicaid to be non-covered which were provided to Medicaid recipients during any period of covered service may be billed to the recipient and other responsible party. The amounts covering these items shall not be listed as an amount received from other sources.

C. Payments to independent laboratories for covered services by Medicare now represent 100 percent of the maximum allowable reimbursements (including deductibles and coinsurance). Since the claims are "paid in full" by Medicare, Kentucky Medicaid shall make no further reimbursements for recipients with dual Medicare and Medicaid eligibility.

D. Other Lab and X-ray providers shall be reimbursed for covered services at sixty (60) percent of the global fee for each covered procedure.

APPENDICES

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

MEDICAID PROGRAM FISCAL AGENT INFORMATION

The Kentucky Department for Medicaid Services' fiscal agent, effective December 1, 1995, shall be the Unisys Corporation. Unisys may be reached as follows:

UNISYS CORPORATION ADDRESSES

Accident & Work Related Claims
Post Office Box 2107
Frankfort, KY **40602**

Adjustments & Claims Credits
Post Office Box 2108
Frankfort, KY 40602

Cash Refund
Post Office Box 2108
Frankfort, KY 40602

Claims Submission
Post Office Box 2101
Frankfort, KY 40602

Prior Authorization
Post Office Box 2103
Frankfort, KY 40602

Provider Relations (Inquiries)
Post Office Box 2100
Frankfort, KY 40602

Third Party Liability
Post Office Box 2107
Frankfort, KY 40602

Electronic Claims Submission
Post Office Box 2016
Frankfort, KY 40602

Unisys Corporation Telephone Numbers:

Kentucky		Out-of-State	
Drug Prior Authorization:	**800-807-1273**	**Drug Prior Authorization:**	**502-226-1140**
Electronic Claims:	**800-205-4696**	**Electronic Claims:**	**502-226-1140**
Provider Relations:	**800-807-1232**	**Provider Relations:**	**502-226-1140**

Automated Voice Response System:
Claims Status Inquiries: 800-807-1301
KenPAC Eligibility: 800-807-1301
Third Party Liability Eligibility: 800-807-1301

HAP-346
(7/92)

KENTUCKY MEDICAID PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the-Listed licensed medical professionals has entered into financial arrangements with _____
(FACILITY NAME)

_____, for the purpose of providing
(CITY) (STATE)
his/her services to patients of this facility, and that currently on file in this facility is a Statement of Authorization (MAP-347) executed by-each of these individuals which authorizes payment by the Kentucy Medicaid Program to _____ for services provided to eligible Kentucky Medicaid
(FACILITY)
Program recipients.

NAME	PROFESSIONAL'S MEDICARE NUMBER	PROFESSIONAL'S LICENSE NUMBER	SPECIALTY	DATE OF FACILITY EMPLOYMENT

SIGNATURE: _____

NAME: _____

DATE: _____

KENTUCKY MEDICAID
Provider#: _____

MAP-343 (Rev. 5/86)

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to infonn the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act, or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician, or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and- policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

PENALTIES

Section 1909. (a) Whoever--

(I) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than 510,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) 'as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(l) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or' service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned. for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title: and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial Certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money,.donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital. skilled nursing facility, or intermediate care facility, or

(8) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in who e or in part) under the State plan,

hall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not ore than five years, or both.

MAP-343 (Rev. 5/86)

3. **Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.**

4. In **the event of a change of ownership of an SNF,** ICF, **or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.**

5. In the event the named **Provider in this agreement is an SNF,**

ICF, **or ICF/MR/DD this agreement shall begin on _____, 19___, with**

conditional termination on _____, 19___, and shall automatically

terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE : _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE : _____

DATE : _____

MAP-343 A
(11/91)

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid **or will** be **paid to** any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, ***or*** **an** employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL **"Disclo**sure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this **certification** be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts **under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.**

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

MAP-344 (Rev. 8/93)

KENTUCKY MEDICAID PROGRAM

Provider Information

1. _____ (Name) (County)

2. _____ (Physical Location Address: Street, Route)

3. _____ (City) (State) (Zip Code)

4. _____ (Office Phone # of Provider) (Billing Office Phone # and Contact Person)

5. _____ (Pay to Address, if Different From Physical Location)

6. _____ (City) (State> (Zip Code)

7. _____ (Federal Employee I.D. #) a. _____ (Social Security #)

9. _____ (License #) 10. _____ (Medicare #) 11. _____ (UPIN #)

12. _____ (Licensing Board) 13. _____ (Original License Date)

14. _____ (CLIA #) 15. _____ (Type of Certificate) (Attached)

16. Physician/Professional Specialty Certification Board:

_____

1st _____ Date _____

2nd _____ Date _____

Attach Copy of Board Certification.

17. Federal DEA # and Date Assigned: _____

18. Practice Organization/Structure:

_____ (1) Corporation
_____ (2) Partnership
_____ (3) Individual
_____ (4) Sole Proprietor
_____ (5) Public Service Corporation
_____ (6) Estate/Trust
_____ (7) Government/Non-Profit

19. If Corporation, list name and address of officers:

(Corporate Office Address) (Telephone #)

(City) (State) (Zip Code)

20. If partnership, list name and address of partners:

21. If sole proprietor, give name, address, and phone number of owner:

22. Control of Medical Facility:

_____ Federal _____ State _____ County _____ City
_____ Charitable or Religious _____ Proprietary (Privately-Owned)
_____ Other

23. If facility is government owned, list names and address of board members:

President/Chairman

_____

Member: _____

Member: _____

24. Distribution of beds in facility:

Acute Care _____ Psychiatric _____ Swing _____

Nursing _____ MR/DD _____

25. Fiscal Year End: _____

26. Administrator: _____ Phone #_____

27. Assistant Administrator: _____ Phone #_____

28. Controller: _____ Phone #_____

29. Accountant or CPA: _____ Phone #_____

30. Management Firm: _____

31. Lessor: _____

32. Has this application been completed as the result of a change of ownership or a change of tax ID number for a previously enrolled Kentucky Medicaid provider?

____Yes ____No

If yes give previous Kentucky Medicaid provider #: _____

33. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____ Date: _____

Name: _____

Title: _____

Return all enrollment forms, changes, and inquiries to:

Medicaid-Provider Enrollment
CHR Building, Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

_____

Date: _____ Staff: _____

MAP-380 (Rev. 04/90)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered intoasof the ___ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____,
Name and Address of Provider
hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

_____,
(Type of Provider and/or Level of Care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided torecipientsof the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes canpliance with the following certification required of each individual claim transmittal by electronic media:

   "Thisistocertifythatthetransmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KM?@. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All prwisions of tbe Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the prwider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

BY: _____
Signature of Prwider

Contact Name: _____

Title: _____

Date: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY: _____
Signature of Authorized Official
or Designee

Name: _____

Title: _____

Date: _____

MAP-246 (Rev. 04/91)

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)
_____, to submit claims via electronic media for services provided to
(Provider Number)
KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request:

3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim *or* application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed:

2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

Date: _____

Contact Name: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

_____
Signature, Representative of the
Department for Medicaid Services

Date: _____